

ITRACONAZOLE PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECTION B - PHYSICIAN INFORMATION		
First Name:	Last Name:	M.D./D.O.
Address:	City:	State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		
SECTION C - MEDICAL INFORMATION		
Medication:	Strength:	Dosing frequency:
Directions for use:		
Diagnosis (Please be specific & provide as much information as possible):		ICD-10 CODE:
Is itraconazole being prescribed for disseminated histoplasmosis in a HIV infected patient? Yes ___ No ___		
For Allergic Bronchopulmonary Aspergillosis (ABPA): Does the patient have an associated diagnosis of asthma or cystic fibrosis? Yes ___ No ___		
For Aspergillosis, Blastomycosis, or Empiric therapy for febrile neutropenia: Has the patient previously received treatment with Amphotericin B? Yes ___ No ___ If yes, dates of therapy _____		
Has treatment with amphotericin B failed to treat the patient's condition or was the patient unable to tolerate treatment with amphotericin B? Yes ___ No ___ If yes, describe intolerance: _____		
For all other diagnoses please list previous medication trials below:		
Medication (Include Strength and Directions)	Dates of Therapy	Reason for Discontinuation
Did the patient experience an <u>intolerance/ adverse reactions</u> , or has a <u>documented contraindication</u> to treatment with at least two other agents used to treat their condition? Yes ___ No ___ If yes, please provide details: _____		

Physician Signature: _____ **Date:** _____

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